DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **04-18**	2. STATE: **TEXAS**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: **September 01, 2004**	

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY **2005** **$ 69,854,518** b. FFY **2006** **$ 68,607,675**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **SEE ATTACHMENT**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **SEE ATTACHMENT**

10. SUBJECT OF AMENDMENT:
This amendment proposes to amend §355.8063, concerning the reimbursement methodology for inpatient hospital services. The proposed amendment restores Medicaid Graduate Medical Education reimbursement based on funding available in SFY 2005. The proposed amendment also modifies the payment methodology for high-volume Standard Dollar Amount add-on payments while increasing the overall amount of these payments. The effective date of the amendment will be September 01, 2004.(

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **David J. Balland** **Interim State Medicaid/CHIP Director** **Post Office Box 13247** **Austin, Texas 78711**
13. TYPED NAME: **David J. Balland**	
14. TITLE: **Interim State Medicaid/CHIP Director**	
15. DATE SUBMITTED: 9-30-04	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9-30-04	18. DATE APPROVED: November 30, 2004
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP - 1 2004	20. SIGNATURE OF REGIONAL OFFICIAL: Dennis G. Smith
21. TYPED NAME: Dennis G. Smith	22. TITLE: Director, CMSO

23. REMARKS:

FORM HCFA – 179 (07-92)

(q) Hospitals with 100 or fewer licensed beds and certain hospitals with more than 100 licensed beds. The policies in this subsection apply only to hospital fiscal years beginning on or after September 1, 1989 for hospitals with 100 or fewer licensed beds at the beginning of the hospital's fiscal year or hospital fiscal years beginning on or after September 1, 2003 for hospitals with more than 100 licensed beds at the beginning of the hospital's fiscal year, located in a county that is not in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget (OMB) and designated by the Centers for Medicare & Medicaid Services as a Sole Community Provider (SCH) or Rural Referral Center RCC. At tentative cost settlement of the hospital's fiscal year (with subsequent adjustment at final cost settlement, if applicable), the state agency or its designee determines what the amount of reimbursement during the fiscal year would have been if the state agency or its designee reimbursed the hospital under similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248, Tax Equity and Fiscal Responsibility Act (TEFRA). This determination is made without imposing a TEFRA cap. If the amount of reimbursement under the TEFRA principles is greater than the amount of reimbursement received by the hospital under the prospective payment system, the state agency or its designee reimburses the difference to the hospital.

(r) Reimbursement to out-of-state children s hospitals. For admissions on or after September 1, 1991, the standard dollar amount for out-of-state children's hospitals is calculated as specified in this subsection. The state agency or its designee calculates the overall average cost per discharge for in-state children's hospitals based on tentative or final settlement of cost reporting periods ending in calendar year 1990. The overall average cost per discharge is adjusted for intensity of service by dividing it by the average relative weight for all admissions from in-state children's hospitals during state fiscal year 1990 (September 1, 1989 - August 31, 1990). The adjusted cost per discharge is updated each year as additional final settlements are completed using the time frames described in subsection (n) of this section and by applying the cost-of-living index described in subsection (n) of this section. The resulting product is the standard dollar amount to be used for payment of claims as described in subsection (e) of this section. The state agency or its designee selects a new cost reporting period and admissions period from the in-state children's hospitals at least every three years for the purpose of calculating the standard dollar amount for out-of-state children's hospitals.

(s) Reimbursement of inpatient direct graduate medical education (GME) costs. The Medicaid allowable inpatient direct graduate medical education cost, as specified under similar methods and procedures used in the Social Security Act, Title XVIII, as amended, effective October 1, 1982, by Public Law 97-248, is calculated for each hospital having inpatient direct graduate medical education costs on its tentative or final audited cost report. Those inpatient direct medical education costs are removed from the calculation of the interim rate described in subsection (b)(7) of this section and not used in the calculation of the provider's standard dollar amount described in subsection (c) of this section. No Medicaid inpatient direct graduate medical education cost settlement provisions are applied to inpatient hospital admissions prior to September 1, 1997. Effective September 1, 2004, providers with Medicaid allowable direct graduate medical education costs as described in this subsection will receive a pro rata share a $51,046,452 pool established in the General Appropriations Act for the current state fiscal year.

Deleted: of their annual GME cost based on available funding as prescribed by the General Appropriations Act for the current state fiscal year. Total payments shall not exceed $51,046,452. The amount and frequency of interim payments will be determined based on appropriations made specifically for GME reimbursement.

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(4) An eligible hospital will receive quarterly supplemental payments. The quarterly payments will be one-fourth of the lesser of:

(A) The difference between the hospital's Medicaid inpatient billed charges and Medicaid payments the hospital receives for services provided to fee-for-service Medicaid recipients. Medicaid billed charges and payments will be based on a twelve consecutive-month period of fee-for-service claims data selected by the state agency; or

(B) The difference between the hospital's "hospital specific limit," as determined under Appendix I to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals (DSH)) and the hospital's DSH payments as determined by the most recently finalized DSH reporting period.

(5) For purposes of calculating the "hospital specific limit" under this subsection, the "cost of services to uninsured patients" and "Medicaid shortfall", as defined by Appendix I to Attachment 4.19-A, the amount of Medicaid payments (including inpatient and outpatient supplemental payments) that exceed Medicaid cost will be subtracted from the "cost of services to uninsured patients" to ensure that during any state fiscal year, a hospital does not receive more in total Medicaid payments (inpatient and outpatient rate payments, graduate medical education payments, supplemental payments and disproportionate share hospital payments) than their cost of serving Medicaid patients and patients with no health insurance.

(u) In accordance with other provisions of this attachment, a high volume adjustment factor will be included in the calculation of the state fiscal year 2003,and 2004 (September 1, 2002 through August 31, 2004) standard dollar amount as described in subsection (a)(4) of this section. Effective September 1, 2004, high-volume payments previously made as an add-on percentage adjustment factor to the standard dollar amount will made according to subsection (u)(3) of this section.

(1) Eligible Hospitals. All non-state owned or operated, non public, DRG reimbursed hospitals located in urban counties with a population greater than 100,000, and Medicaid days greater than 175% of the mean Medicaid days in the base period will be eligible for a high volume adjustment to their standard dollar amount. The base period for determining the mean Medicaid days and hospitals eligible for the high volume adjustment to the standard dollar amount in state fiscal year 2003 is state fiscal year 2001 (September 1, 2000 through August 31, 2001). The base period for determining the mean Medicaid days and hospitals eligible for the high volume adjustment to the standard dollar amounts in state fiscal year 2004 is state fiscal year 2002 (September 1, 2001 through August 31, 2002). Medicaid days will be based on hospital claims data selected by HHSC. County population will be based on the 2000 United States census.

(2) All eligible hospitals in counties with a population less than 1,000,000 will receive a high volume adjustment factor of 6.50% for state fiscal year 2003 and a high volume adjustment factor of 3.25% for state fiscal years 2004; eligible hospitals in counties with a population greater than 1,000,000 will receive a high volume adjustment factor of 10.25% for state fiscal year 2003 and a high volume adjustment factor of 3.25% for state fiscal years 2004.

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(3) High-volume payments recognize the higher medical assistance costs and indigent care cost of hospitals that treat higher levels of low-income and indigent patients. Eligible hospitals are defined as non-state owned or operated, non-public, hospitals located in urban counties with Medicaid days greater than 160% of the mean Medicaid days. High-volume payments totaling $22,500,000 shall be allocated in proportion to uncompensated care loss for eligible hospitals participate in the current year DSH program. High-volume payments totaling $63,808,065 shall be made to eligible hospital in proportion to Medicaid inpatient days of service. Payments under this provision shall be made annually based on current year finalized Medicaid DSH claims data. The state shall adjust the high volume payments in accordance with applicable Medicaid upper limit regulations. Any adjustment shall be made on a proportional basis in order to allow eligible hospitals to participate to the fullest extent possible within the limits on disproportionate hospital payments. HHSC shall use current year DSH data to determine Medicaid days. County population will be based on the 2000 United States census.

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